Occupational Therapist or Occupational Therapy Assistant License Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Occupational Therapy Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in ink. It is your responsibility to submit the correct forms required.

- ☐ **Application Fee**. This fee is non-refundable. You can check the **fee page** for current fees.
- ☐ **1. Demographic Information:**
  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.
- ☐ **Legal Name:** List your full name, first, middle, and last.
- ☐ **Definition of legal name:** "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.
- ☐ **Birth date:** Provide the month, day, and year of your birth.
- ☐ **Birth place:** Provide the city, state and country where you were born.
- ☐ **Address:** List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.
- ☐ **Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.
- ☐ **Email:** Enter your email address, if you have one.
- ☐ **Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.
- ☐ **2. Personal Data Questions:**
  All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.
- ☐ If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**
List in date order all of your education including college, university, technical or professional training to practice occupational therapy. Request your school or program to send an official transcript to this office. If you need more space, attach a piece of paper.

☐ **4. National Board for Certification in Occupational Therapy Certification:** (NBCOT) (Limited Permit Applicants) If you are applying for a Limited Permit, you and your sponsor must sign and date the Limited Permit Attestation portion of the application. It is your responsibility to contact NBCOT. Examination dates and deadlines are established by NBCOT and are strictly adhered to. Contact NBCOT at **www.nbcot.org** or 301.990.7979.

☐ **5. Experience:**
List in date order all of your experience and practice from date of graduation from professional college. If you need more space, attach a piece of paper.

☐ **6. Other License, Certification, or Registration:**
List all states and/or jurisdictions, U.S. and foreign, where credentials are or were held. List all credentials, active, inactive and expired and licensure type. If you need more space, attach a piece of paper.

☐ **7. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours of education and training is required. Course content can be found in **WAC 246-12-270**.

☐ **8. Limited Permit/Sponsor Information:** (Your sponsor must hold a current WA OT License.) Your sponsor(s) must complete and sign this portion. The signature(s) must be original. Photocopies and faxes will not be accepted.

☐ **9. Limited Permit Attestation:** (To be completed by Applicant)
If you are applying for a Limited Permit you must initial and date the Limited Permit Attestation.

☐ **10. Applicant's Attestation:**
You must sign and date this for us to process the application. Read this very carefully.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Washington State Department of Health

License Requirements

Thank you for applying to become a licensed Occupational Therapist or Occupational Therapist Assistant in Washington State. To expedite the license process, please be sure the following information is included with your application.

- ☐ **A Limited Permit** is available only to new graduates waiting for the National Board for Certification in Occupational Therapy (NBCOT, formerly AOTCB) examination or results. You must have graduated from an approved program. Please refer to RCW 18.59.040(7) and WAC 246-847-010(8) and WAC 246-847-115.

- ☐ **Jurisprudence Examination.** Study the Washington State Occupational Therapy Practice Laws (RCW 18.59 and WAC 246-847). After you take the Jurisprudence exam print your certificate of successfully passing the exam and include the certificate with your application packet.

  The following require primary source verification, they will only be accepted when mailed directly to the department from the source. These items must not be included with your application. They must be sent directly to the Department of Health, Occupational Therapy Credentialing.

- ☐ **Official transcript.** Your transcripts must show successful completion of your fieldwork and degree conferred. If you were internationally educated, see special instructions below.

- ☐ **Letter from your school.** (Limited permit applicants) If you are a recent graduate applying for a license and your transcripts are not yet available, you may be issued a limited permit upon submission of a letter from your program director verifying successful program completion and date of graduation. **A full license will not be issued to you until an official transcript has been received.**

- ☐ **NBCOT Verification.** If you have taken the NBCOT exam you must have the NBCOT send a letter of good standing and/or verification of having passed the NBCOT examination directly to us. To have verification sent to this office, contact the National Board for Certification in Occupational Therapy, Inc., 12 S Summit Ave, Suite 100, Gaithersburg, MD 20877-4150 or call 301.990.7979 or www.nbcot.org.

- ☐ **Other License, Certification, or Registration Verification**
  A completed verification form must be received from every state or jurisdiction where you hold or have held a health care practitioner credential.

Internationally Educated Applicants

If you were educated outside the United States, you must supply the following information in addition to the items listed on the preceding pages. If information is not in English, an English translation signed by the translator must be submitted with the official document. Be advised further documentation may be required in addition to the documents:

☐ **Other License, Certification, or Registration Verification**
A completed verification form must be received from every state or jurisdiction where you hold or have held a health care practitioner credential.

Complete Part I of the enclosed **Affidavit/Employment Verification** form for every position held as an occupational therapist or occupational therapy assistant within the past three years.

Have each employer complete Part II of the enclosed form for every position held as an occupational therapist or occupational therapy assistant within the past three years. Verifications will only be accepted if mailed to this office from the employer or direct supervisor.

Important note for internationally educated applicants: Once all documentation is received, the completed application and supporting documents must be presented to the full board for decision according to **WAC 246-847-120**. Scheduled board meetings are listed on our **Web site**. All documents must be received in our office 30 days prior to scheduled board meeting.

Other Information:

Note: You cannot practice occupational therapy until your license is issued.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0278010000

Occupational Therapist or Occupational Therapy Assistant Application

Application as an: ☐ Occupational Therapist ☐ Occupational Therapy Assistant

Application for:
☐ Original license (I have taken the NBCOT exam but am not licensed/registered.)
☐ Interstate Endorsement (I am licensed/registered in another state.)
☐ Limited Permit (I am a recent graduate awaiting the exam/results.)

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth: City | State | Country

Address

City | State | Zip | County

Country

Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City | State | Zip | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

Credential # _____ Issue Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐

3. Education

List in date order all of your education including college, university, technical or professional training for occupational therapy. Request your school or program send an official transcript to this office. If you need more space, attach a piece of paper.

Schools Attended Full Name, City and State	Degree/Certificate Earned	Attendance	
		From (mm/yyyy)	To (mm/yyyy)

4. National Board for Certification in Occupational Therapy (NBCOT)

If you are an interstate endorsement applicant, or an individual who has taken and passed the NBCOT exam but never licensed, request a letter verifying your certification is (was) in good standing.

Certification Number _____

Certification is: ☐ Current ☐ Nonrenewable

☐ Not current due to: ☐ Other (attach explanation)

5. Experience

List in date order all of your experience and practice from date of graduation from professional college. If you need more space, attach a piece of paper.

Attendance		Name and address of institute, place of practice	Type of experience or specialty
Start mm/yyyy	End mm/yyyy		

6. Other License, Certification, or Registration

List all states, jurisdictions, U.S. and foreign, where health care credentials are or were held. List all credentials, active, inactive and expired, and license type. Request the state or jurisdiction send official verification directly to this office.

☐ I have never been registered, certified or licensed to practice occupational therapy in any jurisdiction.

State/ Jurisdiction	License Type	License		Method of License	Expiration Date
		Year issued	Number		

7. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

8. Limited Permit/Sponsor Information (Your sponsor must hold a current WA OT License.)

The following section must be completed by your sponsoring occupational therapist if you wish to work as an occupational therapist/assistant until release of your examination scores. A limited permit cannot be issued without this information. NBCOT's Authorization to Test (ATT) letter is valid for 90 days and the applicant must test within that time frame. Please send original to DOH. Photocopies and faxes will not be accepted.

Date _____

Name of Employer _____ Telephone _____

Employer's Address _____

City _____ State _____ Zip _____

Sponsor's Name _____ License No. _____

I have read Chapter RCW 18.59 and WAC 246-847 and agree to sponsor the above named applicant.

Signature of Sponsor _____ Date _____

9. Limited Permit Attestation (To be completed by Applicant)

I certify I fully understand it is my responsibility to take the NBCOT examination within the 90 days of my valid Authorization to Test (ATT) letter. NBCOT must send my exam scores to Washington State Occupational Therapy Credentialing. I further understand if I should fail to do the above items my Limited Permit will become invalid. I am aware Limited Permits become invalid upon exam failure or 30 days after notification of a passing score.

Applicant's Initials	Date

10. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

Washington State Department of Health
Occupational Therapy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Other License, Certification, or Registration Verification

The individual below is applying for license as an Occupational Therapy or Occupational Therapy Assistant in Washington State. To assist the Occupational Therapy Credentialing in their review, please complete the following information and return directly to the address located above.

Thank you for your cooperation.

Name of licensee _____

License number _____ Issue date _____ Expiration date _____

Issued on the basis of: ☐ State examination ☐ Reciprocity/ Endorsement

☐ NBCOT ☐ Other

Has licensee's license ever been suspended, revoked or subject to other disciplinary action?

☐ Yes ☐ No

If yes, please explain _____

_____

_____

Seal

Signature of verifier _____

Title _____

State board _____

Date _____

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Washington State Department of Health
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PO Box 47877
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360.236.4700

Employment Verification/Affidavit For Internationally Educated

Internationally educated applicants **Only** must fill out this form required by WAC 246-847-120.

Name of facility _____ Telephone #_____

Name of direct supervisor _____ Title of direct supervisor_____

Street address _____

City _____ State _____ Zip _____

(This section to be completed by applicant)

Applicant **must** complete this affidavit for **each place of employment** during the three years immediately prior to the date of application for a Washington license. You may duplicate this form as necessary.

I certify I provided occupational therapy services at the facility named above during the time period:

The capacity in which I was employed; including job title, specific duties, and nature of clientele are listed below:

Beginning date_____ Ending date:_____

The capacity in which I was employed; including job title, specific duties, and nature of clientele are listed below:

Job title	Specific duties	Nature of clientele

I certify the information I provided above is true to the best of my knowledge. I understand if I provide any false information, my license may be denied, suspended or revoked.

Signature _____ Date_____

(This section to be completed by supervisor/personnel manager and returned to the above address)

I certify _____
Name of applicant

Satisfactorily provided services at this facility in the capacity of an occupational therapist/occupational therapy assistant during the time period: Beginning date_____ Ending date: _____

List his/her specific duties _____

Name _____ Date_____

Signature _____
Person completing this form (printed)

Title _____ Telephone number_____
Person completing this form (printed)

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

Occupational Therapy RCW.....RCW 18.59

Occupational Therapy WAC ..... WAC 246-847

NBCOT .....http://www.nbcot.org/

On-Line

AIDS Training Resources ..... Reference Page

Occupational Therapy Practice Board Program ..... Web site